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ABSTRACT

This paper examines recent formulations derived from different lines of conceptual development within psychoanalytic theory in relation to the anorexic and bulimic syndromes. The case history, clinical picture, and course of treatment of a bulimic adolescent girl are reviewed. This discussion illustrates the profound consequences upon cognition of primary failures in maternal empathy and holding. The patient's manifestation of the convergence of sensorimotor representation, an inchoate sense of self, complex symbiotic dynamics within the context of profound anaclitic neediness, and a powerful focus on the consumption and rejection of food are examined. Following this review, a comprehensive formulation derived from self-psychology, psychodynamic developmental and cognitive theory, and object relations theory is advanced. Emphasis is placed on tracing clinical symptoms to their developmental origin, providing a more comprehensive understanding of the symptoms themselves, and securing the formation of a more accurate treatment program. (NRB)

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A Case Illustration

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Contemporary Psychoanalytic Perspectives on Eating Disorders: A Case Illustration

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Over the past 20 years there has been an increasing coverage, both in scientific and popular publications, of eating disorders, especially anorexia, and more recently bulimia. The purpose of this paper is to bring recent formulations derived from different lines of conceptual development within psychoanalytic theory to bear on the anorexic and bulimic syndromes. I will briefly review the chaotic history, vexing clinical picture and turbulent course of treatment of a 17-year-old adolescent girl. Finally, a comprehensive formulation derived from self-psychology, psychodynamic developmental and cognitive theory, and object relations theory will be advanced with a view toward tracing clinical symptoms to their developmental origin, providing a more comprehensive understanding of the symptoms themselves, and securing the formation of a more accurate treatment program.

C is a 17-year-old white adolescent girl who presented a striking appearance. Tall, slender, blond haired, and fashionably yet modestly attired, she presented a startling discrepancy between how she appeared and the severe pathology described in her records. C is the oldest of three children, having two younger half brothers from her mother's second marriage. C's weighed 106 pounds, far below her ideal weight of 135-140 pounds.

Months before admission to an inpatient adolescent unit she exhibited temper tantrums, her school performance deteriorated, and she vomited wildly. She began to binge eat consuming two pounds of sugar daily, she ransacked cupboards, drank quarts of milk, and vomited into garbage bags which she stashed under her

bed. C's need to elicit a response from her parents became increasingly imperative. Slashing a tendon in her wrist and cutting her foot swiftly led to hospitalization.

Mrs. K, C's mother, describes her own childhood and adolescence as uncomfortably similar to C's: "I did poorly in school like C, I was tough, unhappy, got into lots of trouble with drinking and partying." She slashed her wrists when she was 17 and has struggled with depression most of her life. Mrs. K's identification with C is complicated because she views the turning point of her life to be when she was "kicked out" of home at age 19, pregnant with C. This experience has served as a paradigm of separation for both Mrs. K and C.

C was born out-of-wedlock without complications, but Mrs. K adamantly insisted she felt nothing for the child. "I didn't want to hold her or feed her. I was disgusted to have a baby." During these early years C was seduced into complying with her mother's own needs. C was most remembered for her voracious appetite. During the course of family therapy, Mrs. K admitted, "...the more she needed the less I had."

By the time C was 8 years old, her mother had remarried, divorced, given one child up for adoption, suffered two miscarriages, and had given birth to two sons in rapid succession. Between C's eighth to fourteenth year, Mrs. K raised the three children, earned an LPN degree, and struggled to support the family. She met and married her third husband, an unemployed alcoholic when C was 15.

By high school--fatigued by struggles to separate within a symbiotic matrix, dizzied by frequent, unpredictable moves, and both hungry for and repulsed by contact, C took to school truancy, drug abuse, staying out late at night, crash dieting, and finally frenzied spurts of gorging and purging in a frantic attempt to lose weight which ultimately led to hospitalization.

Early therapy sessions with a male resident were characterized by almost random attempts to deal with C's anxiety to the point where she could sit in an office for one-half hour. Her behavior seemed to have a fetching, "come after me"--"hide and seek" quality. On the ward she reopened old cuts, and gorged-vomited in a frantic manner, occasionally storing the vomitus under the bed, in draws, or in her closet. An epiphenal session occurred when she bolted out of the hour and the therapist followed her. She was able to maneuver her frail body into a locker and with the therapist leaning against a wall opposite her, at a safe-enough distance, they were able to finish the session. She talked about a comment that her mother made that C would "be on her own" after discharge. This meant C would not be able to return to her mother, that she was not wanted. In subsequent sessions powerful feelings of abandonment and rage were enacted by completely refusing to attend sessions or the therapy being conducted "on the run" with C darting away and then suddenly stopping to talk and just as quickly fleeing. Her actions and feelings were interpreted as C "talking with her feet" and demonstrating her feelings about being left and wondering frightenedly who would take care of her, if her needs would be met. She was also testing the therapist in a vigilant, hyperalert way to see if he could be trusted. While preoccupied with being cared for and wanted, C maintained a penetrating alertness to and exquisite awareness of the immediate concrete ebb and flow of her environment. The therapist not only felt his actions and inactions microscopically scrutinized, but C's own vigilance evoked a marked countervigilance in the therapist. He picked and chose his words carefully, felt seduced into offering generous portions of support and reassurance, and frequently felt either inhibited or out of control.

In time, C's fragile boundaries were able to accept "hunches" her therapist had about material which she could hear and digest without feeling "invaded." C's vomiting gradually decreased during this stage and she began to gain weight. When her therapist took a vacation C talked about how people leaving felt like they were cutting a piece out of her.

After breaking up with her boyfriend, C appeared profoundly depressed and the ward staff observed a resumption of vomiting. However C was able to bring up the issue of vomiting in therapy and was able to relate it insightfully to "gross" feelings of having been left by her boyfriend, feeling lonely and empty because of it, and gorging to "fill the gap." Feeling "like a mess" and "gross" led to vomiting. The "gap" she realized was the love her mother had not given her and that she was "so hungry for." She related that abuse was the only kind of love she knew. In following sessions C described violent scenes where her mother yelled, threatened, and actually hit her. This material filled many treatment hours and was accompanied by profound anaclitic depression but also the emergence of other affects including anger as she was better able to test reality and identify her mother's unpredictable behavior as stemming from her pathology as opposed to her own behavior. C's cognitive capacities were becoming decentered and increasingly abstract. This process was in tandem with improved reality testing and access to a wider array of affects which were, in turn, more subtle, clearly differentiated, and verbalized.

A Developmental and Structural Formulation

C dramatically illustrates the profound consequences upon cognition (concreteness, egocentricity, subjectivity) of primary failures in maternal empathy and holding. In her development and clinical presentation, C manifests the convergence of sensorimotor representation, an inchoate sense of self,

complex symbiotic dynamics within the context of profound anaclitic neediness, and a powerful focus on the consumption and rejection of food. Lidz et al. (1976) offers the following poetic description of the sensorimotor, action world of the adolescent "...supplies that do away with the unbearable sense of emptiness are...substituted for the supplier; food that can be gorged is sought instead of the feeder; the sexual act replaces the lover; and drugs are found to be a more reliable source of comfort than a living object" (p. 340). The compelling communication embellished in C's symptoms is not a cry for food but for the need gratifying functions of the object. As Sugarman (1981) notes, it is through the action sequence of eating that the need gratifying function of the object can be represented cognitively and affectively.

Highly conflictual symbiotic wishes abound in which there is a desperate hope to consummate a longed for dream--the return to the primary dyad where all of one's needs are met eternally. In the case of C's gorge-vomiting one sees the wish as well as the defense. Although symbiotic urges can occur at all levels of psychopathology (Smith, 1977) in the borderline bulimic patient these dynamics reflect a profound deficit in underlying psychological structures. These patients have a defective representational capacity because of failures in primary maternal empathy. Specifically, failures in maternal mirroring within the context of a holding environment have a debilitating, disintegrating effect on the experience of self which in turn stifles cognitive development and leads to the premature and precocious development of defensive, compensatory structures.

The inability of the mother to provide an adequate holding environment, including the capacity to empathically mirror C's "spontaneous gestures" resulted in a premature defensive identification with the mother's own pathology

which was taken in as a core sense of self, a "false self" lacking in vitality and affective relatedness, predisposed to anaclitic depression, exquisitely egocentric, and both distrustful of and painfully dependent on the environment (the symbiotic mother) as the only source of gratification, aliveness, and survival.

It is within this context that C's gorge-vomiting symptoms may be understood. C's structural weakness, her impaired representational capacity and extreme vulnerability to anaclitic depression, promotes powerful fantasies of fusion with the symbiotic mother and threatens loss of self against which she struggles constantly. The act of gorging becomes the need gratifying conduit to a sensorimotor representation of the symbiotic mother. As Sugarman (1981) emphasizes, it is the action of eating which is essential in order to regain a mercurial representation of the need satisfying mother. However, the intensity of C's anaclitic needs arouse a variety of psychodynamic conflicts including the negative symbiotic experience of fusion and loss of self. Through action sequences, often prompted by separations and other empathic failures, C graphically enacts conflicts surrounding needs for and loss of a need gratifying symbiotic mother.

For C, the formation of a viable, holding environment in the hospital with its constituent elements of structure, predictability, and empathy was an important vehicle for a resumption of the normative separation-individuation process with an enhanced capacity to represent objects and their need satisfying functions internally. This slow process was in concert with a parallel maturation of cognitive and affective functioning from sensory-motor to increasingly abstract and verbal forms. Transference paradigms matured unevenly exhibiting the mutual effect of evolving representational capacities and the

internalizing effect of the holding environment. For the therapists and the treatment team to be able to "hold" C empathically meant to accept the reality of her aggression without being overwhelmed by it, to trust in a loving potential in C in spite of her difficulties expressing it, and to trust the possibility that life has something valuable to offer her while recognizing the reality of her limitations. The aim of treatment with C was poetically depicted by Rilke: "Once the realization is accepted that even between the closest human beings infinite distance continues to exist, a wonderful living side by side can grow up, if they succeed in loving the distance between them, which makes it possible for each to see the other whole against the sky."

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